

**Michigan Health Information Technology Commission**  
– An Advisory Commission to the Michigan Department of Community Health -

**2013 Annual Report**

Fulfilling Michigan Public Act 137-2006 “The HIT Commission shall annually report and make recommendations.”

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## **Executive Summary**

In 2006, the Michigan Legislature created the Health Information Technology Commission to “facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in the state.” As an advisory body to the Department of Community Health, the Commission provides guidance and oversight of health information technology (HIT) and health information exchange (HIE) initiatives in Michigan. Throughout 2013, the Commission played an instrumental role in the development and ongoing monitoring of the Michigan Health Information Network (MiHIN), Medicaid EHR Incentive Program, Michigan Center for Effective Information Technology Adoption (M-CEITA), and Southeast Michigan Beacon Community (SEMBC).

In the past few years, Michigan has made significant progress towards the development of an interoperable health care information infrastructure. With the assistance of the EHR Incentive Program, M-CEITA, and SEMBC, health care providers have adopted and begun to utilize Electronic Health Records (EHRs) to coordinate and improve the delivery of supports and services. MiHIN, the Department of Community Health, and other Health Information Exchange organizations have successfully established common infrastructure to support data sharing across the Michigan health care system. The HIT Commission has served as a forum to discuss and resolve complex issues related to these efforts and develop a statewide strategy for facilitating health information exchange.

The HIT Commission made several recommendations over the past year to encourage the development of statewide services and standards for health information exchange. First, the Commission recommended that the MiHIN and the Department of Community Health collaborate with the Michigan Healthcare Cyber Security Council to develop a Statewide Cyber Security Plan. The Commission also recommended that MiHIN, the Diversion Council, and CIO Forum work together to create a common consent form for disclosing behavioral health information. Finally, the Commission strongly encouraged MiHIN to publish the criteria for organizations to become a Qualified Data Sharing Organization and connect to MiHIN.

In 2014, the HIT Commission plans to focus on revising the statewide HIE strategy for health information exchange to incorporate new goals and address upcoming challenges in the health information exchange environment. The Commission will continue to be active on areas such as cyber security, consent management, and meaningful use. The Commission will also explore new areas of HIT and HIE such as engaging consumers and providers, addressing identity management issues, and integrating behavioral health and long term care providers into the HIE ecosystem.

## Introduction and Overview

The Michigan Health Information Technology (HIT) Commission was created in May 2006 as an advisory commission to the Michigan Department of Community Health (MDCH) through the passage of Public Act (PA) 137-2006. The HIT Commission's purpose, membership, appointment process, frequency of meeting, scope of activities, and other requirements are detailed in PA 137-2006. See appendix A for a copy of PA 137-2006.

As outlined in PA 137-2006, the purpose of the HIT Commission is to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in the State as well as advance the adoption of health information technologies throughout the State's health care system.

In 2009, Congress passed the American Recovery and Reinvestment Act (ARRA), which made an unprecedented investment in HIT across the nation. Michigan received approximately \$250 million in HIT investment through the ARRA. The HIT Commission has become an integral part of monitoring initiatives in Michigan funded by ARRA and advising MDCH on actions that will promote the most effective and efficient use of the funding. Through adherence to the Open Meetings Act, the HIT Commission has also come to play a unique role in ensuring that all ARRA funded HIT programs in Michigan are operating transparently and serving the best interests of the public. In 2013, the HIT Commission focused on monitoring the sustainability and future direction of the ARRA HIT initiatives leading up to the expiration of the grant funding.

PA 137-2006 requires the HIT Commission to produce an annual report to the Legislature detailing the activities of the Commission and offering recommendations for action. The following report fulfills this requirement.

### ***HIT Commission 2013 Membership***

The 13-member HIT Commission is appointed by the Governor as directed in PA 137-2006. Commissioners serve for four year terms or until a successor is appointed. Each commissioner is appointed to represent a specific stakeholder group as noted below:

1. The director of the department (of Community Health) or his or her designee
2. The director of the department of information technology or his or her designee
3. One individual representing a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1703
4. One individual representing hospitals

5. One individual representing doctors of medicine
6. One individual representing doctors of osteopathic medicine and surgery
7. One individual representing purchasers or employers
8. One individual representing the pharmaceutical industry
9. One individual representing schools of medicine in Michigan
10. One individual representing the health information technology field
11. One individual representing pharmacists
12. One individual representing health plans or other third party payers
13. One individual representing consumers

In 2013, the following appointees served as members of the Michigan HIT Commission. Each individual is listed with their term expiration date and the representative stakeholder group.

**Gregory Forzley, M.D.**, of Grand Rapids, represents doctors of medicine for a term expiring August 3, 2015 and serves as the HIT Commission Chair.

**Toshiki Masaki** of Canton represented purchasers and employers until August 3, 2013 and served as the HIT Commission Vice-Chair. After Mr. Masaki's term expired in August, **Pat Rinvelt** of Ann Arbor was appointed to represent purchasers and employers for a term expiring August 3, 2017.

**Nick Lyon** of Marshall, Designee of the Director of the Michigan Department of Community Health, is appointed for a term expiring August 3, 2016.

**David Behen** of Ann Arbor, Designee of the Director of the Michigan Department of Technology Management and Budget, is appointed for a term expiring August 3, 2016.

**Robert Milewski** of Washington Township represents nonprofit health care corporations for a term expiring August 3, 2014.

**Mark Notman, Ph.D.**, of East Lansing represents schools of medicine in Michigan for a term expiring August 3, 2013. Dr. Notman was reappointed in August 2013, for a term expiring August 3, 2017.

**Thomas Lauzon** of Saint Clair Shores represents health plans or other third party payers for a term expiring August 3, 2014.

**Dennis Swan** of Okemos was the representative for hospitals until August 3, 2013. After Mr. Swan's term expired in August, **Jim Lee** of Lansing was appointed to represent hospitals for a term expiring August 3, 2013. Mr. Lee was reappointed in August 2013, for a term expiring August 3, 2017.

**Larry Wagenknecht, R. Ph.**, of Haslett represents pharmacists for a term expiring August 3, 2014.

**Orest Sowirka, D.O.**, of Sterling Heights represents doctors of osteopathic medicine and surgery for a term expiring August 3, 2015.

**Michael Gardner** of Midland represents pharmaceutical manufacturers for a term expiring August 3, 2016.

**Michael Chrissos, M.D.**, of Ann Arbor represents consumers for a term expiring August 3, 2015.

**Irita B. Matthews** of Grosse Pointe Park represents the health information technology field for a term expiring August 3, 2014.

### ***HIT Commission Schedule of 2013 Meetings***

Public Act 137-06 states that the HIT Commission must meet at least quarterly. All meetings are open to the public and must adhere to the Michigan Open Meetings Act. All meeting dates, times, and locations are posted on the MDCH website ([www.michigan.gov/mdch](http://www.michigan.gov/mdch)) along with meeting agendas, minutes, and materials.

In 2013, the HIT Commission held nine meetings. Below is the 2013 HIT Commission schedule of meetings that were held:

January 17, 2013

February 21, 2013

March 21, 2013

April 18, 2013

May 16, 2013

July 18, 2013

August 15, 2013

September 19, 2013

October 17, 2013

### **2013 Review of Activity**

A brief overview of 2013 HIT Commission activities are listed within this section. The 2013 activities are outlined by the main initiatives and organizations that

presented to the HIT Commission throughout the year and whose work provided the basis for much of the Commission's discussion and subsequent recommendations. Many of the activities highlighted align with the Department of Community Health's 2013 Strategic Priorities. See Appendix B for a copy of the 2013 HIT Commission topics and Appendix C for a copy of the Department of Community Health 2014 Strategic Priorities.

## ***2013 HIT Activities in Michigan***

### **Michigan Health Information Network**

MiHIN is dedicated to improving the healthcare experience and decreasing cost for Michigan's people by supporting the statewide electronic exchange of health information and making valuable data available at the point of care. MiHIN is a public and private nonprofit collaboration between the State of Michigan, the Office of the National Coordinator, sub-state Health Information Exchanges, insurers, payers, providers and patients. For more information please visit [www.mihin.org](http://www.mihin.org)

MiHIN is a shared network for exchanging health information statewide. Numerous organizations have entered into a legal framework for data sharing through MiHIN's network. These organizations are referred to as Qualified Organizations or QOs. During 2013, MiHIN deployed into production a number of shared services for use cases that enable Michigan's providers to meet Meaningful Use requirements for health information exchange. Collaborating in these efforts, are the State of Michigan's Department of Community Health (MDCH), a Government QO; seven sub-state Health Information Exchanges (HIEs) or HIE Qualified Organizations (HIE-QOs); two major Health Plans, or Payer Qualified Organizations (PQOs); and two Virtual Qualified Organizations (VQOs) that participate in specialized use cases.

#### *Government QO:*

1. Michigan Department of Community Health (MDCH)

#### *HIE-QOs<sup>1</sup>:*

2. Great Lakes Health Information Exchange (GLHIE), East Lansing;
3. Ingenium, Bingham Farms;
4. Jackson Community Medical Records (JCMR), Jackson;
5. Michigan Health Connect (MHC), Grand Rapids;
6. Southeast Michigan Health Information Exchange (SEMHE), Ann Arbor;

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<sup>1</sup> Note that HIE-QOs and their affiliated providers are not strictly regionally based

7. Southeast Michigan Beacon Community (SEMBC), Detroit;
8. Upper Peninsula Health Information Exchange (UPHIE), Marquette;

*Payer-QOs:*

9. Blue Cross Blue Shield of Michigan (BCBSM), based in Southfield;
10. Health Alliance Plan (HAP), based in Detroit.

*Virtual QOs:*

11. Carebridge, based in East Lansing;
12. PCE Systems; based in Farmington Hills;

As a result of the combined efforts of MiHIN and the QOs, health information exchange was broadly available throughout Michigan in 2013.

Public Health Services

MiHIN has developed a robust statewide infrastructure for the electronic exchange of data across its network supporting a variety of standard transport mechanisms and also supporting a growing number of use cases (e.g. immunizations, reportable labs, syndromics surveillance, transition of care, and a statewide health provider directory). Some of the use cases are focused on compliance with Meaningful Use (MU) requirements and other use cases (e.g. transitions of care), while not required for MU, offer great value to Michigan's healthcare community by offering more coordinated care that assists in creating improved outcomes. Messages are sent from providers to HIE-QOs and then via MiHIN and its network to an appropriate destination. For Public Health Reporting, the destination is always the MDCH Data Hub, which then forwards messages to the appropriate MDCH registries including the Michigan Care Improvement Registry (MCIR), the Michigan Disease Surveillance System (MDSS), and the Michigan Syndromic Surveillance System (MSSS). For transitions of care, messages are directed to team members actively providing care for a given patient.

More than 11.0 million messages have been received by MiHIN since entering production on May 8, 2012. Now more than a million messages are received by MiHIN during a typical week and this weekly message rate is steadily increasing as more and more provider organizations come onboard through MiHIN and the QOs.

MiHIN provided the capability for HIE-QOs to share immunization data through MiHIN to the State of Michigan through capacity building funds. This funding helped the HIE-QOs enhance their services to providers for electronic Public Health Reporting. By January of 2014, the only path into the State of Michigan for unsolicited Vaccination Update (VXU) records will be through MiHIN.

MiHIN and Michigan Health Connect (MHC) demonstrated the initial operational capability for immunization messages to flow from hospitals into the Michigan Department of Community Health via MCIR. In 2013, Public Health messages were transmitted from 39 counties through HIE-QOs in production to MiHIN and MDCH. Walgreens Pharmacies and Henry Ford Hospital are also in full production sending immunizations via MiHIN. In addition, MiHIN is in the process of final testing with CVS Caremark Pharmacies.

By November 2013, a total of 2,793,469 Public Health messages were successfully transmitted across MiHIN's Health Information Services Cloud™ (HISC) and received by the appropriate repository at MDCH. As of October 1, 2013, Michigan has six HIE- QOs sending production immunization data through MiHIN to MDCH and MCIR.

MiHIN also continues to receive immunization messages for Michigan patients seen by providers in other states such as Indiana where the immunization update (VXU) is received as an HL7 attachment to a DIRECT secure email message.

Additionally, MHC is sending reportable lab messages through MiHIN onto the MDCH Data Hub. The MDCH Data Hub subsequently sends the messages to MDSS. To increase the number of HIE-QOs sending reportable lab messages, MiHIN has provided assistance with the mapping of LOINC and SNOMED codes for reportable lab messages. On October 29, 2013, MiHIN convened "Lab Day" for the HIE-QOs and other organizations to outline the process of reportable labs sent through MiHIN to MDSS; to increase understanding of lab results submission particularly with regard to LOINC and SNOMED coding; and to facilitate an understanding of the Michigan Direct Gateway (MiDiGate™). MiHIN has drafted and distributed a Lab Day Summary of the event.

MiHIN also receives syndromic messages through a successful pilot project. The syndromics pilot began with the UPHIE HIE QO and is expected to continue into 2014.

### Health Provider Directory Services

MiHIN is under contract with the State of Michigan to deploy a statewide Provider Directory. MiHIN's Health Provider Directory (HPD) service has been developed, deployed, and is entering into production. The HPD stores and makes accessible "Electronic Service Information" (ESI) for providers. This information is critical to facilitate electronic communication between providers through secure data transmissions. The HPD service, deployed in the Salesforce.com cloud, allows organizations, EHRs, Direct HISPS, and other Provider Directories to query to obtain ESI, licensing status or other demographic information at the organization/entity/affiliation level, practice unit level, provider level, care team level or other affiliations. Queries can also be geographic, across populations,

or by specialty type. The HPD enables a variety of capabilities such as electronic routing, including delivery and notification preferences, role, identity verification, and legal status. Multiple Michigan-based Qualified Organizations have committed to utilize the HPD and three have completed onboarding/training with others forthcoming. Other states have expressed high levels of interest in using the HPD Service. The East Tennessee Health Information Network (etHIN) has procured HPD Services from MiHIN and is also in the process of onboarding its hospitals in a 17-county region in eastern Tennessee.

MiHIN also participated in a nationally visible pilot project through the ONC Exemplars effort for the Interoperability Working Group. The pilot demonstrated the ability to federate multiple provider directories. MiHIN's "Snowbirds" pilot included the Florida HIE (FLHIE) and Surescripts, which has one of the largest in-production primary care physician directories in the U.S. The successful pilot allowed MiHIN's HPD to send queries to Surescripts' Provider Directory to retrieve Electronic Service Information (ESI) in the form of a Direct Secure Messaging email ID for a Florida provider.

### Transitions of Care Services

After a number of successful pilots in 2012-2013, MiHIN has successfully deployed a Statewide Transitions of Care Service starting with a Statewide Admit, Discharge, and Transfer (ADT) use case. Nine Michigan hospitals are now in production, submitting ADTs through a QO to MiHIN which then re-sends the ADT messages to Health Plans and eventually, to any care team member in an active care relationship with the patient for whom the ADT was generated. MiHIN's Active Care Relationship Service helps route inbound ADTs for one patient to all members of that patient's care team, including providers in a particular practice unit in a Physicians Organization. MiHIN has deployed an active care relationship infrastructure (ACRS) and is populating the ACRS service with patient-provider attribution data.

In 2014 MiHIN will begin piloting their Medication Therapy Management services. Future pilot projects will focus on sharing data when there is a 'human-in-the-loop' to validate current medication lists and update medication management plans as entered by pharmacists.

### HealtheWay eHealth Exchange / MiHIN Common CCD Gateway/Common Broker

In 2013, MiHIN deployed a Common CCD Gateway using the CONNECT 4.2 standard to support Cross-QO Queries that enables Continuity of Care Documents (CCDs) to be exchanged. MiHIN held a Cross-QO Query Day on June 27<sup>th</sup>, 2013 that provided a forum for the QOs to discuss current issues, commonalities, and future plans.

The Common CCD Gateway, sometimes referred to as the Common Broker, was also utilized by MiHIN in 2013 to successfully complete all testing and onboarding with the national eHealth Exchange, operated by HealtheWay (formerly NwHIN. MiHIN was the first organization to pass the new testing required by HealtheWay and the first to complete testing using the Consolidated Clinical Document Architecture (C-CDA). MiHIN accomplished this by first deploying a tool called “FedSim,” a simulator that could emulate the messaging behavior of the SSA, VHA, or CMS so that MiHIN could thoroughly test its messaging before beginning the onboarding testing with HealtheWay. Similarly, MiHIN also deployed a companion tool called “EdgeSim” which could mimic the messaging behavior of a HIE-QO or a hospital EHR by responding to federal agency requests (from FedSim mimicking SSA, VHA, or CMS) with appropriate CCD or C-CDA messages. The two simulators are also utilized for load testing and onboarding testing, as numerous QOs are now aligned to onboard with the federal use cases. For example UPHIE is actively onboarding via MiHIN for the ability to communicate via MiHIN’s eHealth Exchange connection for query use cases with the VHA (VA).

In addition, MiHIN re-sold copies of its Common CCD Gateway and other shared HIE components to the Southeast Michigan Beacon Community (SEMBC) and is now positioned to resell copies to other organizations including those in other states.

### Progress for Electronic Health Information Exchange

In 2013, MiHIN and the HIE-QOs made significant progress with all seven HIE-QOs across a wide variety of use cases ranging from public health reporting to transitions of care and care team coordination. The seven HIE-QOs: MHC, UPHIE, Ingenium, GLHIE, JCMR, SEMHIE and SEMBC, along with MDCH entered into different agreements with MiHIN for new use cases including reportable labs, syndromics, statewide ADTs, active care relationship service, and the health provider directory. Some of the HIE-QOs are actively reviewing additional use cases including federal use cases with the VA/VHA and SSA.

The MiHIN legal framework is defined through the Qualified Data Sharing Organization Agreement (QDSOA), Use Case Agreements, and Statements of Work with pricing information. These legal agreements represent contractual obligations with trading partners. They outline the framework for the types of data sharing that will occur, expectations around access to health information, what uses of information are acceptable, and the expectations for organizations’ use of the information exchanged. They also require extensive privacy and security safeguards including mandatory cyber-liability insurance.

MiHIN has entered into an agreement with Surescripts allowing users of Surescripts Clinical Interoperability Network to send electronic health information to the State of Michigan's Public Health reporting systems through MiHIN and the

Michigan Department of Community Health. MiHIN and Surescripts entered into an agreement based on the DirectTrust technical, legal, and business security and privacy standards for HISC™ connectivity.

### MiHIN Direct Strategy

MiHIN led Michigan by introducing Direct Secure Messaging (DSM) and Michigan's first Direct Health Information Services Provider (HISP) in 2012. In 2013, Michigan's HIE QOs followed MiHIN's lead by selecting their own Direct HISP vendors. MiHIN has completed the next step in its MiHIN DIRECT strategy by:

1. Developing the Medical Information Direct Gateway (MiDiGate™) and applying for a patent with the United States Patent and Trademark Office (USPTO). MiDiGate establishes standardized inboxes for various use cases and processes inbound Direct secure messages to ensure they are sent to the correct MDCH or Health Plan repository.
2. Completing a formal request for proposals (RFP) for a "Direct Marketplace for Michigan" to create a pool of pre-approved Direct vendors from which future QOs can select a Direct vendor that is compatible with the existing Direct vendors deployed in Michigan.

### MiHIN Operations Advisory Committee

Pursuant to the QDSOA legal agreements, every QO is entitled to representation on a group entitled the MiHIN Operations Advisory Committee (MOAC), which oversees MiHIN operations and advises the MiHIN Associate Director. The MOAC also makes recommendations to the MiHIN Board of Directors. Additionally, the MOAC has formed and charted six MOAC Working Groups:

1. MOAC Governance Working Group
2. MOAC Use Case Working Group
3. MOAC Privacy Working Group
4. MOAC Security Working Group
5. MOAC Productions and Operations Working Group
6. MOAC Integration and Architecture Working Group

The MOAC Working Groups meet monthly or bi-weekly as needed and their work products and recommendations are forwarded to the primary MOAC for review and further action as needed.

### MOAC Governance Working Group

This group is primarily charged with the resolution of impasses that may occur as working groups convene or in the event that a conflict persists. The MOAC

Governance Working Group is accountable for documenting all conflicts, and if necessary or appropriate, advancing them to the MiHIN Board of Directors. This group meets on an as-needed basis with no regular schedule.

#### MOAC Use Case Working Group

This working group is responsible for the definition, authorship, and approval of all Use Case Agreements (UCAs). This working group serves as the focal point for integration of well understood data sharing scenarios as well as incubation efforts, such as demonstration pilots used to distill the relevant components of what needs to be articulated in each Use Case including the development of Implementation Guides, technical specifications and instructions (implementation roles and responsibilities).

In 2013, the MOAC Use Case Working Group approved a total of 18 use cases:

- Reportable Lab Submission
- Receive Syndromics
- Immunization Submission
- Convert Syndromics
- Immunization Query for History and Forecast
- Statewide ADT Notification Service
- ADT Payer Generic
- Submit Data to Health Provider Directory
- Basic Query to Health Provider Directory
- Advanced Query to Health Provider Directory
- Submit Data to Active Care Relationship Service
- Transitions of Care ADT Notification Service
- Cross-QO Patient Query
- Non-Federal eHealth Exchange Patient Query
- CMS Electronic Submission of Medical Documentation
- SSA Disability Determination
- VA Patient Query
- eHealth Exchange Participant Patient Query

The following new use cases and Use Case Agreements are presently under consideration to support Public Health: Chronic Disease Registry, Social Security Disability Determination Cancer Registry, Birth Defect Registry and Newborn Registry.

The MOAC Use Case Working Group is also developing a mechanism to prioritize and score Use Cases. This will provide a better understanding of the impact of Use Cases.

#### MOAC Privacy Working Group

The purpose of this working group is to review and analyze Federal and Michigan privacy laws and regulations to determine their impact on the exchange of health information via MiHIN and among QOs.

Work products include policies, procedures and national standards-based “best practices”; recommendations to member organizations for implementation; and if requested by the MOAC Use Case Working Group, review of Use Case Agreements for potential privacy related issues or concerns.

A MOAC Privacy White Paper has been drafted and is in review. MiHIN expects to present a final version of the MiHIN Privacy White Paper to the Health Information Technology Commission in the second quarter of 2014.

The MOAC Privacy Working Group is also facilitating the creation of a single standard consent form for Behavioral Health in the State of Michigan. This effort to create a standard consent includes the CIO Forum (behavioral health CIOs), MDCH, DTMB, the Diversions Council, and the Recipients Rights Group. The HIT Commission has been heavily engaged and very active in the continuing success of this effort. The Privacy Working group has also drafted plans to educate providers and physicians regarding a standard consent form.

#### MOAC Security Working Group

This working group (WG) is responsible for the development of MiHIN’s security policies and procedures and for keeping the policies and procedures up-to-date with industry best-practices and new standards such as the new NIST framework issued by the White House earlier this year. The efforts of the Security WG incorporate a broad range of topics such as: authentication, authorization, access controls, identity management, identity federation, intrusion detection monitoring, vulnerability assessments, security audits, security awareness and training.

This working group is also charged with establishing the necessary operational and environmental processes that support these policies and procedures and alignment with evolving regulatory frameworks. Recent security policies from the MOAC Security Working Group include a Breach Notification and Escalation Policy to be put into effect for breaches that affect MiHIN or any connected data sharing organization.

When the MOAC Use Case Working Group has defined a use case with security-related aspects, the Security working group has responsibility to review relevant security aspects accordingly.

MiHIN offers comprehensive security assessment and monitoring services to evaluate the security of organizations and their IT infrastructure and help organizations understand and evaluate risks. MiHIN has developed a suite of security vulnerability assessments and threat assessment services that include:

- External and internal vulnerability assessments
- Security penetration testing by certified ethical hackers
- Continuous threat monitoring services
- Security consulting and planning
- Social engineering engagements
- Security awareness training

In early 2013, MiHIN, the MOAC, and a number of leading statewide and national security experts developed a Cyber Security White Paper and presented their findings to the HIT Commission for recommendations. The HIT Commission directed MiHIN to present the Cyber Security White Paper to Governor Snyder's Michigan Cybersecurity Council. Soon afterwards, the Michigan Healthcare Cybersecurity Council was formed consisting of more than 30 CIOs, CSOs, and security experts from major Michigan health systems, health plans, and State agencies.

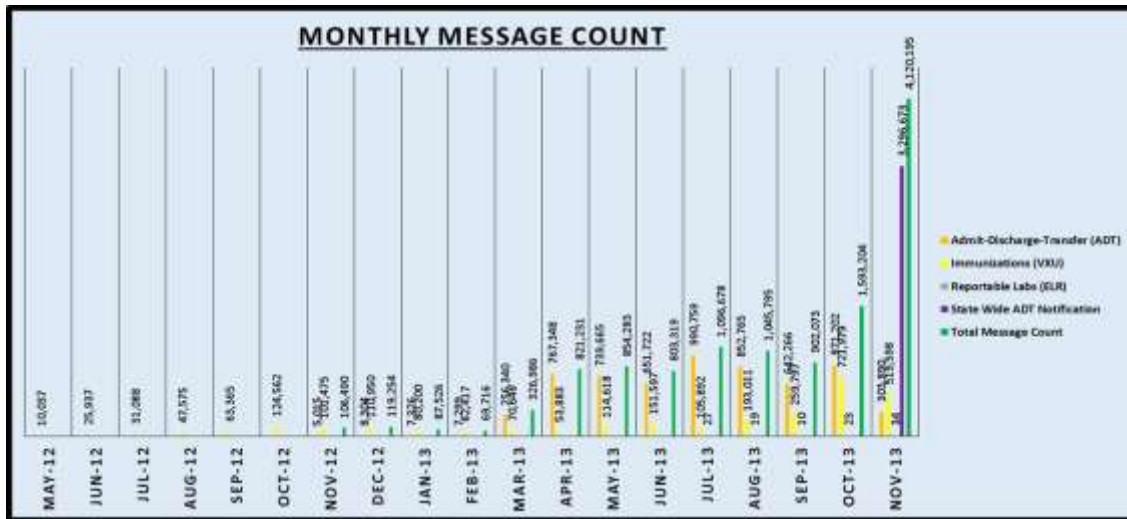
#### MOAC Production and Operations and Integration/Architecture Working Groups

This working group is responsible for the timely resolution of issues that impact production and for the immediate or near-term matters affecting routine operation. This working group is also responsible for scheduling new services or insuring functionality with the minimum of disruption and maximum coordination among affected parties.

#### MOAC Integration and Architecture Working Group

This working group is responsible for investigating solutions to technical issues and alternative architectural options to resolve systemic challenges; establish new functionality or scalability; or to mitigate potential threats to operations and environmental integrity. This working group provides context for future discussion by and actions of the Production and Operations Working Group.

**Monthly message count since May 8th, 2012**



## 2014 Initiatives

During 2014, MiHIN will continue the initiatives outlined in its charter:

1. MiHIN provides the requisite shared infrastructure or “core services” that enable statewide sharing of health information.
2. MiHIN offers a robust legal framework to enable multi-stakeholder data sharing that crosses non-profit & for profit organizations, the State of Michigan, federal government, and interstate entities.
3. MiHIN helps minimize the external burden on providers and constituents imposed by state or federal regulations through the transparent adoption of standards and reusable approaches for data sharing.
4. MiHIN serves as a neutral convener of multiple stakeholders (health plans, hospitals, Public Health, physicians, pharmacists, corporations, constituents, etc.) to address common data sharing issues and to recommend or develop cooperative approaches and solutions.
5. MiHIN acts as an accelerant to validate technological approaches and uncover unintended consequences of a given approach in an effort to foster more timely adoption, more successful implementations, at lower costs to operate.
6. MiHIN helps raise the awareness of important technology capabilities and the impact emerging technology, communication, and advanced forms of data sharing or access can have on improving health for Michigan's people.

7. MiHIN works to minimize the State of Michigan's financial burden by seeking external funding, leveraging existing capabilities across organizational silos, and creating an environment for multi-organization collaborative pooling of resources.

## **Medicaid Electronic Health Record Incentive Program**

The Electronic Health Record (EHR) Incentive Program is focused on Medicare and Medicaid providers that adopt EHR technology and use the technology according to a specific set of criteria called Meaningful Use (MU). The Medicare program is administered on a federal level, while states are charged with the administration of the Medicaid program. In Michigan, the Medicaid program has been operational for nearly three years and has issued nearly \$200 million in federal funding for HIT adoption. The HIT Commission continues to spend considerable time exploring the EHR Incentive Program and providing feedback to MDCH on its administration and implementation.

The HIT Commission recognized that the Medicaid EHR program is focused on encouraging the adoption of EHRs in provider offices and hospitals throughout Michigan. The HIT Commission receives regular updates on the number of professionals and hospitals that received incentive funding as well as the total amount of incentive funding expended within the program.

In 2013 the HIT Commission also explored outreach strategies, how to effectively go-live with MU collection and provided recommendations on how to further promote the EHR Incentive Program. The HIT Commission will continue to monitor and provide input to the program in 2014 as the program enters into Stage Two of MU and begins planning for Stage Three of MU.

## **MDCH Data Hub**

The Michigan Department of Community Health Data Hub, also known as the MDCH Data Hub, is the State government's internal HIE infrastructure that enables the exchange of health care information among state systems, primarily the Medicaid Enterprise. The MDCH Data Hub infrastructure includes a Master Person Index (MPI), a provider index (health provider directory), security services, a messaging service, a cross-enterprise document store (XDS) capability, an audit/logging service, and an analytics service-all necessary for the proper and secure performance of interconnected community health systems.

During 2013, MDCH Data Hub focused on projects aimed at increasing Michigan's health information exchange capabilities. The Data Hub concentrated on efforts to allow healthcare providers to report their data to the State of Michigan and expand the integration of MDCH Medicaid and Public Health Systems.

The MDCH Data Hub continues to focus on increasing technical capabilities in order to ensure its Medicaid IT systems are integrated, interoperable and assist Medicaid Providers with meeting Meaningful Use requirements and Medicaid system advancements.

#### MDCH Achievements:

Below is a brief description of each system and its functionality and the project activity concluded or begun in 2013.

##### *Michigan Care Improvement Registry (MCIR)*

The Michigan Care Improvement Registry was developed to track immunization information in both children and adults. MCIR benefits health care organizations, schools, licensed childcare programs, and Michigan citizens by consolidating immunization information from multiple providers. MCIR also has the ability to assist with pandemic flu preparedness and can track vaccines and medications during a public health emergency.

Receipt of Immunization information via HIE into MCIR began in May 2012 and now comprises 18% of all immunizations received, up from 10% in February 2013. MCIR is experiencing a doubling of activity via the SOM HIE every 2-3 months. In November 2013, MCIR began receiving immunizations from its first corporate submitter, Walgreens. Other corporate submitters will soon follow.

The MDCH Data Hub's Master Person Index (MPI) was established in 2012 initially populated with 17 MDCH data sources. In 2013 MDCH worked with the Michigan Care Improvement Registry staff on the first Real-Time Integration of the MCIR system with the MPI. In August 2013, the MPI/MCIR Real-Time Integration project went live with the implementation of the Use Case Person Search-Individual. Searches for individuals on the MCIR web based application now interoperate between the two systems. Work continues on the next Use Cases (Person Search-Guardian/Parent, Add/Update Person Record, Merge/Unmerge Person Record) and will include how the systems need to interact with regard to HIE inbound HL7 messages.

Work commenced in 2013 on the development and implementation of Michigan HIE's first bidirectional message, MCIR Query Forecast/Query History. For this new message, providers will be able to use their EHRs to request patient information from the MCIR system on what shots their patient has received and what they are due for. The MCIR Query by Parameter message is planned for pilot production in March 2014.

##### *Michigan Syndromic Surveillance System (MSSS)*

The Michigan Syndromic Surveillance System is designed and implemented to facilitate public health rapid detecting and response to unusual outbreaks of illness that may be the result of bioterrorism, outbreaks of infectious disease or other public health threats and emergencies. This is a real time system based on HL7 messaging. The system gives Michigan public health officials early detection alerts and enables MDCH epidemiologists to take appropriate intervention actions quickly.

The Michigan Syndromic Surveillance System went into production via the HIE platform in July of 2013. Hospitals currently submitting Syndromic data to MSSS will be able to migrate off the legacy submission method transitioning to the use of the new HL7 message. With implementation of the new HL7 message, Providers will now be able to send these messages from their EHRs and receive credit towards meeting Meaningful Use.

#### *Michigan Disease Surveillance System (MDSS)*

The Michigan Disease Surveillance System is a web based communicable disease reporting system developed for the State of Michigan based on national data standards. The system facilitates coordination among local, State and Federal Public Health Agencies for response needed based on the reporting of specified communicable diseases such as Anthrax, Lyme Disease, Botulism, Chicken Pox, Measles, and Sexually Transmitted diseases. It also provides for the secure transfer, maintenance and analysis of communicable disease surveillance information.

Electronic Reportable Lab results have been received from an out-of-state lab since 2012. In September 2013, the Michigan Disease Surveillance System (MDSS) began receiving lab results via HIE from Michigan labs.

#### *MDCH Provider Index (PI)*

The Provider Index will serve as a central repository matching/linking and identification of provider level records, including health providers, businesses, organizations, health plans, and WIC providers.

Memorandums of Understanding were signed in October 2013 between MDCH and LARA in order to receive Licensed Provider and Facility information to begin building the MDCH Provider Index. Medicaid enrolled providers from the MDCH CHAMPS system will also be a source of provider information for the Provider Index. The index will begin being built following an upgrade deployment for the Infosphere Master Data Management software.

#### *Cancer Case Report/Cancer Registry and Birth Defects Report/Specialized Registry*

The Michigan Cancer Surveillance Program operates a statewide cancer incidence registry for the state of Michigan. The registry began as a statewide registry in 1985 under the authority of Act 82 of 1984. This statute established cancer as a reportable disease in the state. Reporting is required of hospitals, laboratories, health clinics, dentists and physicians. Additional information on cancer cases is obtained from nursing homes, hospice and from 20 other state registries which exchange resident case information with the Michigan registry.

The registry has received reports for over 1.5 million cancer patients since it began. This information is used to monitor cancer incidence in Michigan, assess cancer cluster concerns and to facilitate research into the causes and control of cancer in Michigan.

The Michigan Birth Defects Registry contains information on children diagnosed with reportable birth defects in the state of Michigan. This information is reported by hospitals, physicians, genetics counselors and others as mandated by Public Act 236 of 1988. The registry began operation statewide in 1992. It was established to improve statewide identification of children with birth defects and facilitate the assessment of service and referral needs for these children. The Michigan Birth Defects Registry also provides baseline birth defects incidence and mortality rates and trends, serves as a resource for program planners at the state and local level to address the needs of the families involved and provides a resource for research into the risk factors for and causes of birth defects. These activities seek to improve our knowledge concerning the prevention of birth defects and to assure that Michigan children with birth defects have access to available resources and assistance.

In 2013 work commenced on two new messages needed to assist providers with their ability to meet Meaningful Use (MU) requirements, Cancer Case Report and the first message for the MU Specialized Registry requirement. MDCH's Specialized Registry will be a Chronic Disease Registry and the first message will be for the reporting of Birth Defects. No National Standard exists for Use Case *Receive Birth Defects Information*. Michigan is working in collaboration with other states in the hopes that our efforts could be leveraged to create a new national standard. It is anticipated that both messages will be in production in 2014.

### *Privacy and Security*

The MDCH Data Hub has always retained logs in order to meet HIPAA logging and audit requirements. In November 2013, efforts began to leverage State of Michigan enterprise systems to store these logs as well as establish purge procedures and processes to ensure as new traffic is brought into production that appropriate logs are retained.

And finally, with regard to security advancements, MDCH in 2013 awarded the Michigan Identity Credentialing and Access Management (MICAM) contract to build a new more robust Single Sign On system that can handle both citizen access to state systems as well as our existing business partner access to these systems. The effort in 2014 will focus on establishing the infrastructure needed to support MDCH Medicaid applications.

## **Southeast Michigan Beacon Community**

As one of 17 Beacon Communities established in 2010 by the US Department of Health and Human Services and administered by the Office of the National Coordinator for Health Information Technology, the Southeast Michigan Beacon Community (SEMBC) has pursued a mission to improve chronic disease care and associated outcomes in medically underserved and disadvantaged communities--while reducing costs. Today, SEMBC continues its efforts to use Health Information Technology (HIT) and Exchange (HIE) to advance a vision of patient-centered care that uses real-world clinical intervention strategies to deliver significant, measured results.

During the final year of its award period, SEMBC continued to build upon the successes earned in 2011 and 2012 by promoting improved diabetes care and self-management in the original catchment cities of Detroit, Dearborn, Dearborn Heights, Hamtramck, and Highland Park. This progress, achieved on a very aggressive timeline, was made possible through the leadership of a multi-stakeholder board, the efforts of a dedicated SEMBC project team, and the unprecedented support of numerous community partners. SEMBC's work has advanced all three pillars of the Beacon Community Program, with clinical and process interventions that include:

### **I. Improving Cost, Quality and Population Health**

- Practice Transformation: Working with 46 SEMBC-affiliated private practices and FQHCs to pursue IT and HIE-enabled Clinical Transformation; achieving at least a 5% improvement in 5 of 6 target clinical measures.
- Patient Health Navigators: Expanding the scope of the program to engage over 2,300 of 5,300 referred patients with diabetes; assisting them in overcoming non-clinical barriers to managing their health. Significant positive movement was made across tracked measures.

### **II. Testing Innovative Approaches**

- ED Diabetic Patient Identification: Securing the active participation of three large-scale, high-volume emergency departments in an intervention that tested over 25,000 patients, identifying 7,560 previously unknown diabetics and pre-diabetics.
- Super-Utilizer Initiative: Mining data to identify high emergency department and inpatient utilizers for targeted intervention, and redirecting high utilizers to primary care medical homes.
- Retinal Eye Imaging Pilot: Partnering with Kresge Eye Institute (of Wayne State University) in an intervention designed to help determine the workflow and cost implications of performing on-site retinal exams at practices, in an effort to improve screening rates and reduce the threat of diabetic retinopathy.

### III. Building and Strengthening Health IT Infrastructure

- BeaconLink2Health (BL2H): Expanding the reach of SEMBC's Health Information Exchange (HIE) and Clinical Data Repository (CDR) to include a local health system, four physician organizations with over 4,500 providers, all FQHC/FQHC look-alikes in Wayne County, and other free clinics and providers in the region. Over 100,000 active and "consolidated" lives are currently registered in the community CDR; with work continuing on the integration of an additional 700,000 consolidated lives.
- Population Health and Meaningful Use (MU): Developing industry leading technology and capabilities that support population health and MU requirements. The capabilities of BL2H include a virtual visit planner for use as a point-of-care reference, predictive analytics that identify care gaps and alerts, an enterprise master patient index (EMPI) to help maintain consistent and accurate data, transport layer security to provide communication security, and cross-community document sharing (XDS.b) in alignment with MU requirements. BL2H has partnered with JVHL and Quest Diagnostics, becoming the first HIE to in the state of Michigan to integrate laboratory results from Quest. And, through work with Michigan Health Information Network (MiHIN), offers providers with a way to achieve MU-compliant public health reporting of immunization data to the Michigan Care Improvement Registry (MCIR) via their existing EHRs.

- **Leadership and Cooperation:** Participating in multiple state-wide use cases as a recognized Qualified Data Sharing Organization. Convening with other Beacon Communities and EHR vendors to collaborate on a mutually agreed upon set of data and interoperability standards in alignment with Meaningful Use Stage 2 requirements. Collaborating on numerous peer review papers to promote experiences and shared learning. SEMBC has also secured unprecedented in-kind support from vendors toward the transition to longer-term sustainability.

Looking toward the future, SEMBC remains committed to maintaining positive momentum toward developing a foundation for health care delivery in our region that recognizes data as a public good; focuses on the coordination of care across settings; manages medical costs; and meaningfully uses technology to support the overall health of the entire Southeast Michigan population and beyond.

### **The Michigan Center for Effective IT Adoption**

The Michigan Center for Effective IT Adoption (M-CEITA) began as a federally funded ARRA initiative to provide electronic health record (EHR) implementation assistance to primary care providers across Michigan who serve underinsured or uninsured patients. M-CEITA will continue to be federally funded into 2014 for these services to priority primary care providers (PPCPs), but has expanded beyond the initial federal program in several ways which are detailed below. The HIT Commission continues to be the primary focus of all stakeholder input to the M-CEITA program. Specifically, the HIT Commission is charged with supporting, promoting and advising M-CEITA on the direction and activity of the program, through regular review of financial and operational reports for the federally funded program component, and by serving as a liaison to other organizations that also promote HIT adoption.

As 2013 draws to a close, M-CEITA is focused on successfully completing our ONC-funded scope of work to help 3,724 PPCPs reach Meaningful Use. To date, M-CEITA has exceeded its program enrollment goal, has helped over 3,600 providers go live on an electronic health record (EHR), and has assisted over 2,300 of these providers to meet the requirements of Stage 1 Meaningful Use (MU). M-CEITA continues to report about this progress to the HIT Commission through regular presentations and monthly HIT dashboard updates.

At the same time, the M-CEITA program is making available new service offerings through additional funding mechanisms, including support from the Michigan Department of Community Health (MDCH). Our goal is to continue to offer a full program of support for providers across the state. The assistance that providers need from M-CEITA will change over time as a result of healthcare reform, changing regulatory requirements, advanced stages of Meaningful Use

and provider comfort level with technology. As these needs change, the M-CEITA program will continue to develop and adjust our service offerings.

Ideally, M-CEITA services should remain fully subsidized for Michigan providers, since we know from experience that many of the providers who most need assistance don't have the means to pay full price for the services we provide. To that end, in 2013 M-CEITA kicked off a new program funded by the Centers for Medicare and Medicaid Services (CMS) and MDCH to help specialists achieve Meaningful Use. This program offers the same services as the ONC-funded program, but focuses on Eligible Professionals who fall outside the PPCP definition. Through this program, M-CEITA will be able to help 600 specialists achieve Stage 1 Meaningful Use by 2016. Over 100 providers are already enrolled.

In 2013, M-CEITA also made services available at cost to providers who are not eligible for either of the subsidized programs. Through this program, M-CEITA provides support for all years of Stage 1 Meaningful Use, Stage 2 Meaningful Use, Security Risk Assessments, workflow optimization, patient engagement, and Meaningful Use audit preparation.

## **HIT Commission 2013 Recommendations**

Public Act 137-2006 that established the HIT Commission requires that the annual report include recommendations that are delivered to the Michigan Legislature. Throughout the HIT Commission's activities in 2013 the following recommendations emerged and have been reassigned for consideration by the Michigan Legislature. The HIT Commission is committed to working with MDCH and Michigan Legislature to assist in defining the specific details of these recommendations by participating in further dialog.

### ***Develop a Statewide Cyber Security Plan***

Michigan has made progress in encouraging HIT adoption statewide. However, with the increased adoption of HIT and HIE, data breaches, security concerns, and privacy issues have surfaced as a potential barrier. The HIT Commission recommends partnering with the Michigan Healthcare Cyber Security Council, a task force formed as an action from the Governor Snyder's Cyber Security Advisory Council, to review and potentially adopt cyber security recommendations in the Cyber Security White Paper. The Cyber Security White Paper was led by MiHIN and developed by a number of leading security experts statewide and nationally.

### ***Develop a Common Consent Form for Behavioral Health Information***

Multiple stakeholders in Michigan have been working towards developing a consent form for sharing behavioral health information. The HIT Commission meetings served as a forum for these stakeholders to discuss and combine these efforts. The HIT Commission recommends that the CIO Forum, Diversion Council and MiHIN collaborate on producing a common form. This initiative will continue into 2014 activities, in which the HIT Commission will review the final product for formal recommendation to the Department of Community Health.

### ***Develop Qualified Data Sharing Organization Criteria***

The Michigan Health Information Technology Commission strongly encourages MiHIN (the Michigan Health Information Network) to complete the development of Qualified Data Sharing Organization criteria, to publicize and make known those criteria, and to encourage the appropriate organizations to participate in facilitating the exchange of health information throughout the State of Michigan. This recommendation was given to the MiHIN Board after the resolution was unanimously passed during October's 2013 meeting.

## **Forecast of 2014 Activity**

In December of 2013, the HIT Commission participated in a planning meeting focused on the development and maintenance of a strategic plan to guide the implementation of an interoperable health information technology system in 2014. The following areas emerged as important topics for discussion and activity. Please see Appendix E for the graphic of the 2014 HIT Commission topics.

### ***Develop and maintain a strategic plan***

- Develop a roadmap based on the MDCH strategic plan with specific services, timelines, issues, budgets, and marketing
  - Define and establish the metrics for success
  - Support the development of statewide shared services
  - Explore ICD-10 efforts
  - Align state efforts with HIE community, health systems, and the provider community

### ***Identify critical issues***

- Cybersecurity
  - Partner with the Michigan Health Cybersecurity Council (MHCC)
  - Promote legislative input on cybersecurity
- Consent Management

- Support MiHIN and the Diversion Council work with creating a Behavioral Health Common Consent Form
- Statewide Identity Management
  - Engage Master Patient Index, Provider Index, and Credentialing Service stakeholders in expanding as a statewide service

### ***Policies and measures to encourage adoption of HIT***

- HIE Stakeholder Engagement
  - Acknowledge and promote best practices
  - Obtain feedback on current HIE landscape
- Behavioral Health and Long Term Care
  - Encourage stakeholders to include HIE and HIT in data exchange policies

### ***Increase consumer and provider engagement***

- Medicaid Consumer Engagement Initiative
  - Assist Medicaid with developing a statewide consumer, engagement roadmap
  - HIT and HIE education
    - Promote Michigan's HIT and HIE efforts with healthcare providers
    - Highlight to eligible providers that 2014 is critical for obtaining Meaningful Use to avoid penalties
    - Engage the Governor, State, and Federal leaders with Michigan's HIE landscape

# Appendix A: Public Act 137-2006

Act No. 137  
Public Acts of 2006  
Approved by the Governor  
May 10, 2006  
Filed with the Secretary of State  
May 12, 2006  
EFFECTIVE DATE: May 12, 2006

## STATE OF MICHIGAN 93RD LEGISLATURE REGULAR SESSION OF 2006

Introduced by Reps. Newell, Farhat, Vander Veen, Meyer, Moore, Kooiman, Taub, Emmons, Kahn, Huizenga, Walker, Moolenaar, Casperson, David Law, Pearce, Jones, Steil, Wenke, Booher, Hansen, Stewart, Marleau, Caswell, Hildenbrand, Stakoe, Ward, Mortimer, Acciavatti, Ball, LaJoy, Nitz, Baxter, Proos, Caul, Green, Shaffer, Nofs, Sheen, Wojno and Accavitti

## ENROLLED HOUSE BILL No. 5336

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," (MCL 333.1101 to 333.25211) by adding part 25.

*The People of the State of Michigan enact:*

### PART 25. HEALTH INFORMATION TECHNOLOGY

Sec. 2501. As used in this part:

- (a) "Commission" means the health information technology commission created under section 2503.
- (b) "Department" means the department of community health.

(85)

Act No. 137  
Public Acts of 2006  
Approved by the Governor  
May 10, 2006  
Filed with the Secretary of State  
May 12, 2006  
EFFECTIVE DATE: May 12, 2006

Sec. 2503. (1) The health information technology commission is created within the department to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in this state. The commission shall consist of 13 members appointed by the governor in accordance with subsection (2) as follows:

- (a) The director of the department or his or her designee.
  - (b) The director of the department of information technology or his or her designee.
  - (c) One individual representing a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1703.
  - (d) One individual representing hospitals.
  - (e) One individual representing doctors of medicine.
  - (f) One individual representing doctors of osteopathic medicine and surgery.
  - (g) One individual representing purchasers or employers.
  - (h) One individual representing the pharmaceutical industry.
  - (i) One individual representing schools of medicine in Michigan.
  - (j) One individual representing the health information technology field.
  - (k) One individual representing pharmacists.
  - (l) One individual representing health plans or other third party payers.
  - (m) One individual representing consumers.
- (2) Of the members appointed under subsection (1), there shall be representatives from both the public and private sectors. In order to be appointed to the commission, each individual shall have experience and expertise in at least 1 of the following areas and each of the following areas shall be represented on the commission:
- (a) Health information technology.
  - (b) Administration of health systems.
  - (c) Research of health information.
  - (d) Health finance, reimbursement, and economics.
  - (e) Health plans and integrated delivery systems.
  - (f) Privacy of health care information.
  - (g) Medical records.
  - (h) Patient care.
  - (i) Data systems management.
  - (j) Mental health.
- (3) A member of the commission shall serve for a term of 4 years or until a successor is appointed. Of the members first appointed after the effective date of the amendatory act that added this part, 3 shall be appointed for a term of 1 year, 3 shall be appointed for a term of 2 years, 3 shall be appointed for a term of 3 years, and 4 shall be appointed for a term of 4 years. If a vacancy occurs on the commission, the governor shall make an appointment for the unexpired term in the same manner as the original appointment. The governor may remove a member of the commission for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.
- (4) At the first meeting of the commission, a majority of the members shall elect from its members a chairperson and other officers as it considers necessary or appropriate. After the first meeting, the commission shall meet at least quarterly, or more frequently at the call of the chairperson or if requested by a majority of the members. A majority of the members of the commission appointed and serving constitute a quorum for the transaction of business at a meeting of the commission.
- (5) Any business that the commission may perform shall be conducted at a public meeting held in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The commission shall give public notice of the time, date, and place of the meeting in the manner required by the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.
- (6) The commission shall make available a writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function as the commission to the public in compliance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.
- (7) The commission shall ensure adequate opportunity for the participation of health care professionals and outside advisors with expertise in health information privacy, health information security, health care quality and patient safety, data exchange, delivery of health care, development of health information technology standards, or development of new health information technology by appointing advisory committees, including, but not limited to, advisory committees to address the following:
- (a) Interoperability, functionality, and connectivity, including, but not limited to, uniform technical standards, common policies, and common vocabulary and messaging standards.
  - (b) Security and reliability.
  - (c) Certification process.
  - (d) Electronic health records.
  - (e) Consumer safety, privacy, and quality of care.
- (8) Members of the commission shall serve without compensation.
- Sec. 2505. (1) The commission shall do each of the following:
- (a) Develop and maintain a strategic plan in accordance with subsection (2) to guide the implementation of an interoperable health information technology system that will reduce medical errors, improve quality of care, and produce greater value for health care expenditures.

- (b) Identify critical technical, scientific, economic, and other critical issues affecting the public and private adoption of health information technology.
- (c) Provide recommendations on policies and measures necessary to achieve widespread adoption of health information technology.
- (d) Increase the public's understanding of health information technology.
- (e) Promote more efficient and effective communication among multiple health care providers, including, but not limited to, hospitals, physicians, payers, employers, pharmacies, laboratories, and any other health care entity.
- (f) Identify strategies to improve the ability to monitor community health status.
- (g) Develop or design any other initiatives in furtherance of the commission's purpose.
- (h) Annually, report and make recommendations to the chairpersons of the standing committees of the house of representatives and senate with jurisdiction over issues pertaining to community health and information technology, the house of representatives and senate appropriations subcommittees on community health and information technology, and the senate and house fiscal agencies.
- (i) Perform any and all other activities in furtherance of the above or as directed by the department or the department of information technology, or both.
- (2) The strategic plan developed pursuant to subsection (1)(a) shall include, at a minimum, each of the following:
  - (a) The development or adoption of health care information technology standards and strategies.
  - (b) The ability to base medical decisions on the availability of information at the time and place of care.
  - (c) The use of evidence-based medical care.
  - (d) Measures to protect the privacy and security of personal health information.
  - (e) Measures to prevent unauthorized access to health information.
  - (f) Measures to ensure accurate patient identification.
  - (g) Methods to facilitate secure patient access to health information.
  - (h) Measures to reduce health care costs by addressing inefficiencies, redundancy in data capture and storage, medical errors, inappropriate care, incomplete information, and administrative, billing, and data collection costs.
  - (i) Incorporating health information technology into the provision of care and the organization of the health care workplace.
  - (j) The ability to identify priority areas in which health information technology can provide benefits to consumers and a recommended timeline for implementation.
  - (k) Measurable outcomes.

Sec. 2507. The commission or a member of the commission shall not be personally liable for any action at law for damages sustained by a person because of an action performed or done by the commission or a member of the commission in the performance of their respective duties in the administration and implementation of this part.

This act is ordered to take immediate effect.

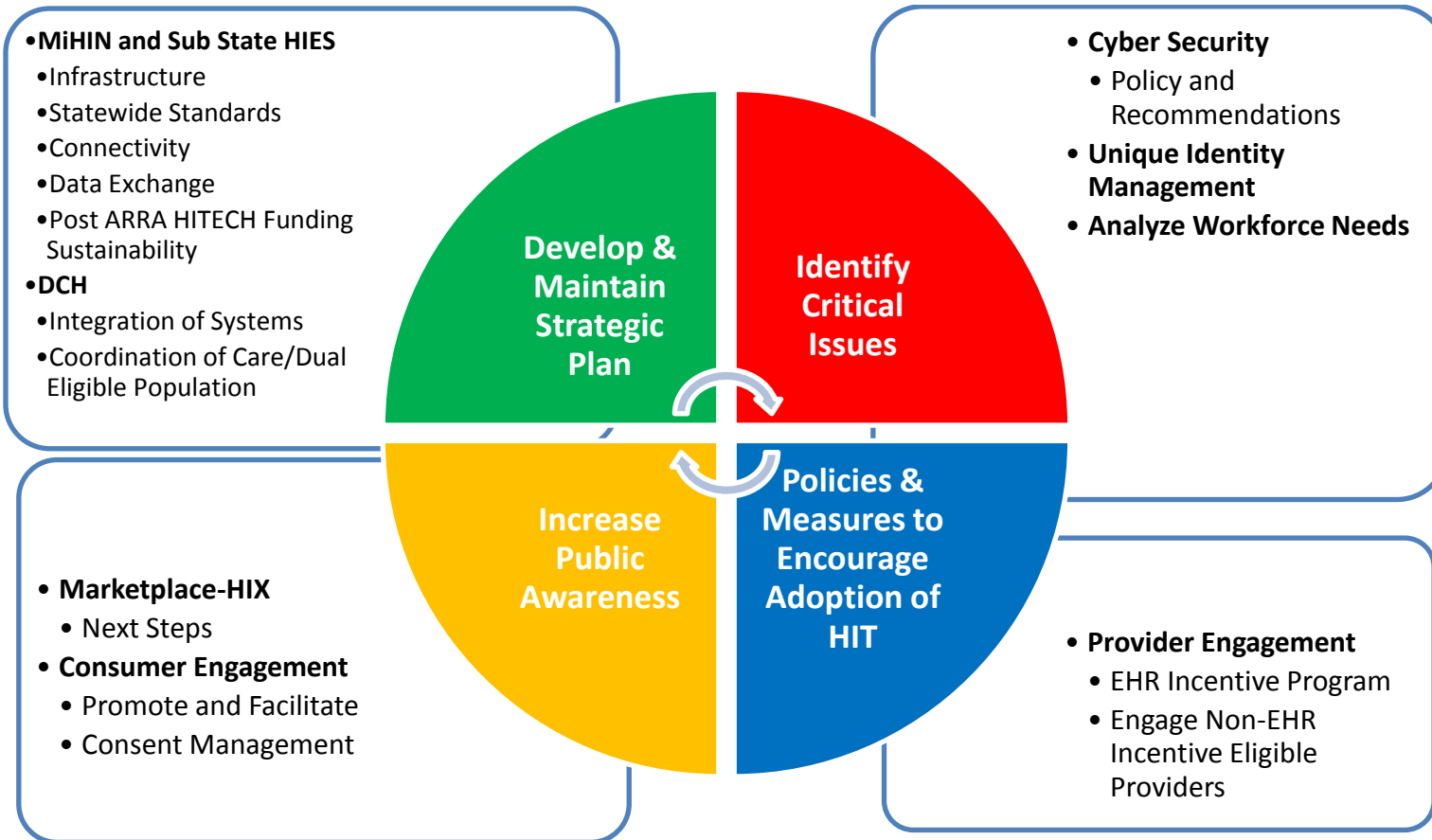
Clerk of the House of Representatives  
 Secretary of the Senate  
 Approved

**Governor**

## Appendix B: 2013 HIT Commission Topics

### 2013 HITC Themes

**Objective:** To recommend and advise the Michigan Department of Community Health on Policy decisions, business and technical needs, and general oversight for the following HIT activities essential to the State of Michigan HIT and HIE landscape during 2013.



## Appendix C: MDCH 2013 Strategic Priorities



### DEPARTMENT OF COMMUNITY HEALTH 2013 STRATEGIC PRIORITIES

#### MISSION

MDCH will protect, preserve, and promote the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.

#### VISION

Improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

#### STRATEGIC PRIORITIES

##### Improve Population Health

- Identify and target chronic care hot spots. (Public Health)
- Implement the Michigan Health and Wellness 4 x 4 Plan to reduce obesity and improve wellness using the MI Healthier Tomorrow campaign. (Public Health)
- Utilize Michigan's Infant Mortality Reduction Plan to address disparities and save babies. (Public Health)
- Identify and improve culturally-sensitive access to all services for persons with disabilities. (Behavioral Health & Developmental Disabilities)
- Establish a strategy for improving the continuum from preconception to early childhood. (Public Health)
- Enhance the safety planning and response to all hazards, public health and health care emergencies. (Public Health)
- Integrate services for physical health and mental health and increase coordination among care providers. (Behavioral Health & Developmental Disabilities)
- Enhance efforts to identify and improve early intervention mental health services for children and youth. (Behavioral Health & Developmental Disabilities)

##### Transform the System of Care

- Establish a fund to provide innovative approaches to improve the health of Michigan citizens. (Policy & Planning)
- Implement regionalization plan for health care services and programs. (Policy & Planning)
- Enhance technical support and identify additional federal opportunities for Federally Qualified Health Centers (FQHC's). (Policy & Planning)
- Support the person centered medical homes model and preserve the safety net. (Medical Services)
- Establish and support policies for a full continuum of services for Long-term Care. (Office of Services to the Aging)
- Improve access to federal benefits and local services for Veterans. (Behavioral Health & Developmental Disabilities)
- Develop opportunities for persons with mental illness and substance abuse issues to receive early intervention services to prevent incarceration. (Behavioral Health & Developmental Disabilities)
- Champion expanding the Health Care Workforce and promoting the positive benefits of health care in stabilizing healthier communities. (Policy & Planning)

##### Reform the Health Care System

- Create an integrated multidisciplinary delivery system with a focus on person-centered models of care. (Policy & Planning)
- Improve fraud identification and prevention to reduce waste and increase accountability. (Office of Health Services Inspector General)
- Focus on quality and outcomes for fee for service and managed care rather than quantity. (Medical Services)
- Streamline the payment and reimbursement process for providers. (Medical Services)
- Develop a standardized method to provide services consistently through the state to improve the quality of care. (Medical Services)

##### Transform the Department of Community Health

- Reinvent MDCH by creating an organizational structure that is effective, efficient, interactive, customer focused, and value driven. (Chief Deputy Director)
- Create and support a culture in which employees feel engaged and take ownership of our mission. (Policy & Planning)
- Establish standards and procedures to enhance customer experience. (Chief Deputy Director)
- Provide and promote leadership development opportunities to all employees. (Policy & Planning)
- Ensure IT systems are unified, usable and meet future business needs. (Chief Deputy Director)

[www.michigan.gov/mdch](http://www.michigan.gov/mdch)

Revised 3/7/13

## Appendix D: MDCH 2014 Strategic Priorities

### Michigan Department of Community Health 2014 Strategic Priorities

#### MISSION

The Michigan Department of Community Health will protect, preserve, and promote the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.

#### VISION

Improving the experience of care, improving the health of populations, and reducing costs of health care.

#### PRIORITY: Promote and Protect Health, Wellness, and Safety

Our focus will always be on creating a healthier, stronger Michigan. In line with the Michigan Department of Community Health's mission, our first and foremost priority is the protection, promotion, and preservation of the health, wellness, and safety of all Michiganders. We remain focused on the continuance of successful population health programs, the implementation and expansion of programs that better meet the evolving needs of residents, and our persistence in remaining prepared to respond to health safety needs as they arise.

#### Objectives:

- Improve access to federal benefits and local services for Veterans.
- Ensure access to culturally and linguistically appropriate services for all Michigan residents.
- Implement an integrated chronic disease strategy that addresses comorbidities, mental health, and chronic care hot spots.
- Increase access to dental care.
- Make Michigan a 'no wait state' for aging services.
- Review the Public Health Code to better meet and anticipate needs of Michigan residents.
- Create an emergency preparedness plan for the aging and disabled populations.
- Realign how Emergency Medical Services are provided and funded.
- Reduce prescription drug abuse and increase compliance.
- Increase immunization rates.



- Build upon the 4x4 Plan to reduce obesity and further collaborate with partners.
- Implement the recommendations of the Mental Health and Wellness Commission.
- Improve response from local communities in emergency situations.
- Reduce disparities in health outcomes.
- Provide comprehensive population health monitoring.

#### **PRIORITY: Improve Outcomes for Children**

In line with Governor Snyder's emphasis on ensuring that children thrive in our state, the Michigan Department of Community Health has placed a specific focus on improving the outcomes for children. We know that the future of our state rests with our youth. Through enhancing resources, improving services, and ensuring a continuity of care throughout a child's lifetime, we can greatly improve the future of our state.

##### **Objectives:**

- Increase services in the community for children and adolescents at risk for and with substance use disorder.
- Enhance efforts to identify and improve early intervention mental health services, including autism, for children and youth.
- Create a plan to educate the courts and community mental health centers about competency laws and the implications for children.
- Utilize Michigan's Infant Mortality Reduction Plan to support healthy babies growth and change in disparities.
- Implement cross-system collaborative strategies to improve health outcomes from preconception through adolescence.

#### **PRIORITY: Transform the Healthcare System**

Michigan is in a very dynamic time of change for the healthcare system. In an effort to be collaborative and better integrated, the Michigan Department of Community Health remains committed to strengthening current systems, addressing gaps between disciplines, and implementing change for the overall improvement of care for Michigan residents.

##### **Objectives:**

- Strengthen mental health, substance abuse, and physical health integration.
- Support the adoption and awareness of Health Information Technology to improve communication, efficiency, customer experience, and health outcomes.

- Improve information technology systems to ensure they are current, deliver timely results, and have increased inter-operability.
- Improve upon the secure sharing and management of data.
- Improve fraud prevention and identification to reduce waste and increase accountability.
- Implement the Healthy Michigan Plan.
- Implement the dual eligibles demonstration (integrated care of Medicaid and Medicare).
- Create an interdepartmental integrated system of long term care.
- Organize healthcare systems and programs by regions.
- Implement the Blueprint for Health Innovation.
- Support an integrated multidisciplinary delivery system with a focus on person-centered care.
- Streamline payment and reimbursement processes for all providers that focus on quality and outcomes, rather than quantity.

#### **PRIORITY: Strengthen Workforce and Economic Development**

In order to provide quality, efficient services for Michigan residents, the Michigan Department of Community Health recognizes the importance of improving the workforce and economic climate within the state. By focusing on increasing opportunities and retaining talent, we firmly believe we can contribute to the growing future success of the State of Michigan.

##### **Objectives:**

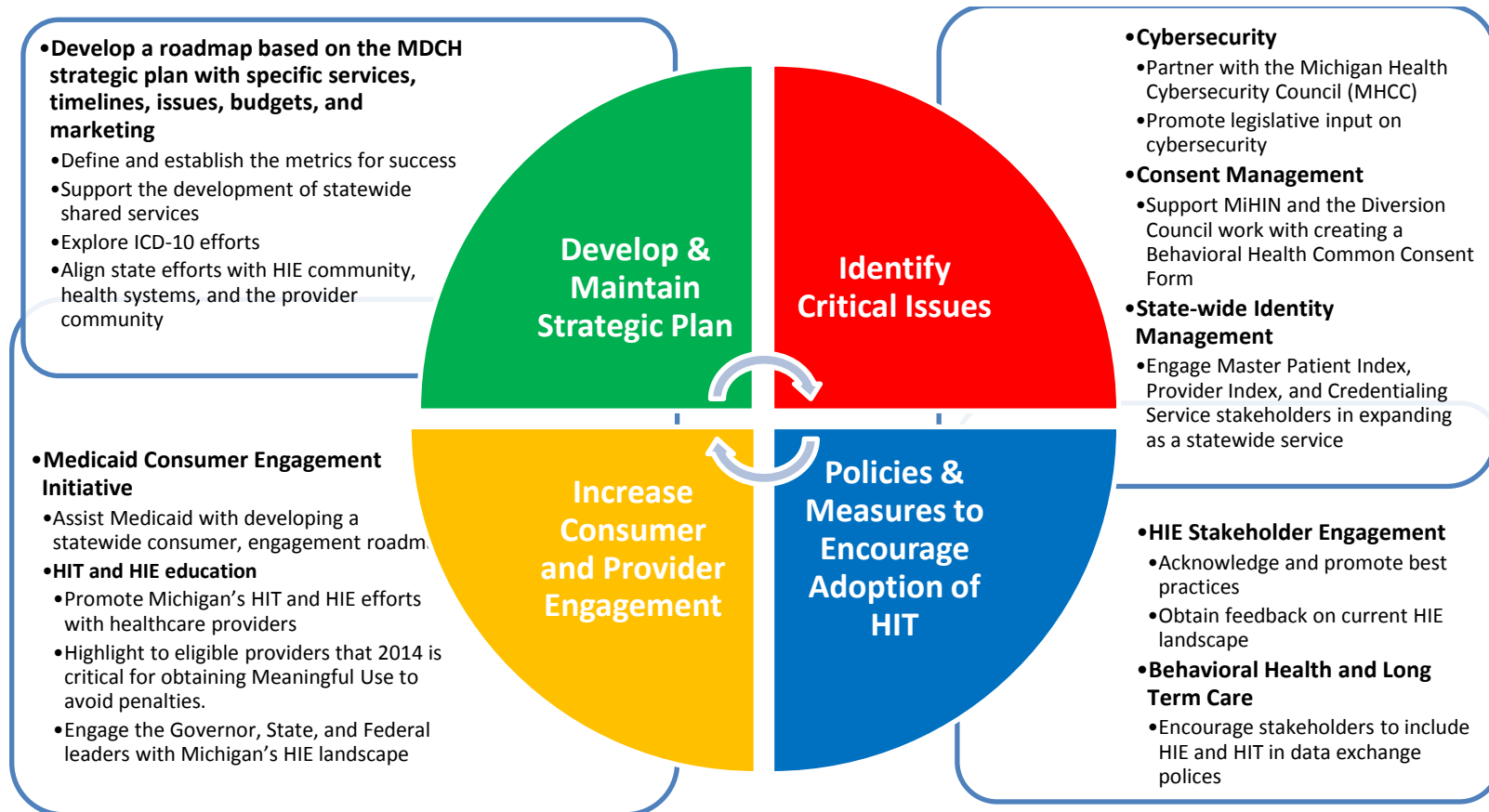
- Implement leadership development, training, mentoring and education enhancement opportunities for employees.
- Support competitive employment opportunities to retain a creative and diversified workforce.
- Develop a robust recruitment strategy for low-applicant, vital jobs.
- Improve communication and employee engagement across the department.
- Utilize measures and metrics to monitor progress, make decisions, and drive performance.
- Support a multitier interdisciplinary healthcare workforce.
- Focus on transparency and open communication with stakeholders and partner agencies.
- Support a culture of process improvement to optimize customer experience.
- Support Michigan in becoming an employment first state.



## Appendix E: 2014 HIT Commission Topics

### 2014 HITC Topics

**Objective:** To recommend and advise the Michigan Department of Community Health on Policy decisions, business and technical needs, and general oversight for the following HIT activities essential to the State of Michigan HIT and HIE landscape during 2014.



## Appendix F: 2013 MI HIT Dashboard – December 19, 2013

### 2013 Goals – December Update



#### Governance Development and Execution of Relevant Agreements

- Use Cases under evaluation: Submit Data to Active Care Relationship Service™ (ACRS), ADT Transitions of Care Statewide Notification Service, Immunization: Query for History and Forecast (revised), Cross-QO query
- Approved Use Cases for MiHIN Common Gateway: (1) SSA eligibility determination (2) eHealth Exchange patient query (3) VA Patient query (4) CMS esMD
- Successful meeting to consolidate standard consent form for Behavioral Health, additional meetings are expected to occur during Dec 2013/Jan 2014

#### Technology and Implementation Road Map Goals

- Query-By-Parameter for Immunization pilots have been moved to March 2014
- A Query-By-Parameter/Immunization History/Forecast Technical Q&A will be held on December 16<sup>th</sup>
- Henry Ford Health Systems/Macomb has gone live with ADTs to MiHIN under the statewide ADT/TOC Use Case
- First ACRS files received from Carebridge/MiPCT for patient-provider attribution in Statewide ADT/TOC service

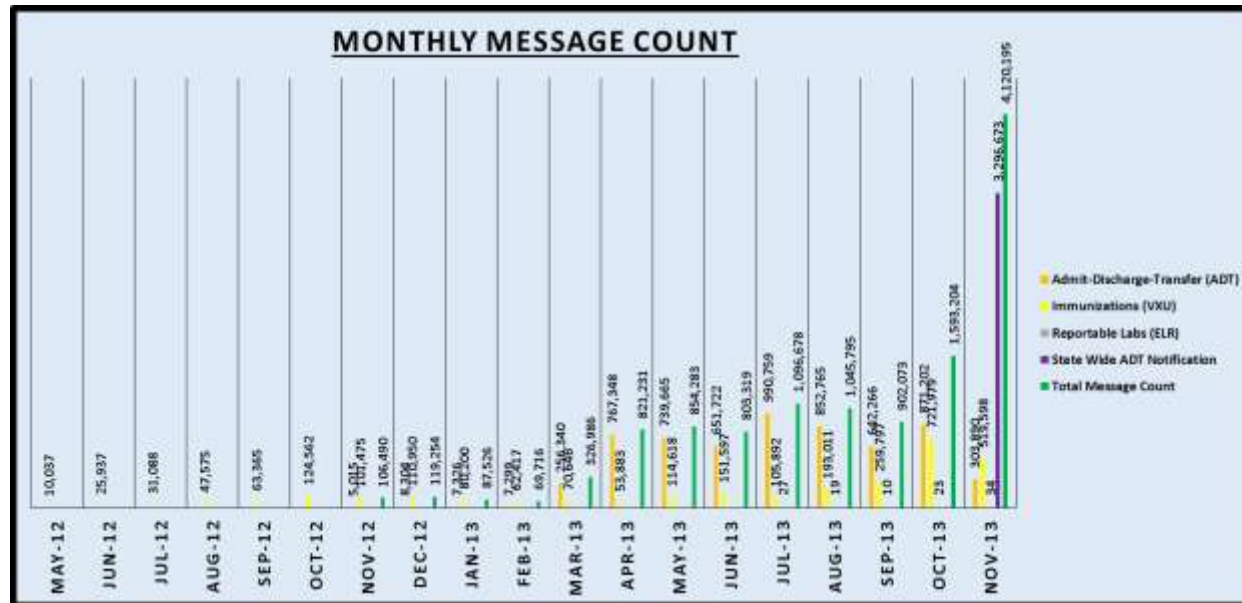
#### QO & VQO Data Sharing

- Pilot for Syndromics reporting still in DQA with UPHIE
- 2 QOs executed SOWs for Directed Integration
- MiHIN now receiving more than 1 million messages/week
- Over 13 million messages received since May 8, 2012
- MHC and GLHIE announced data sharing via DIRECT

#### MiHIN Shared Services Utilization

- Beacon implemented shared HIE components from MiHIN
- SEMHIE implementing shared HIE components from MiHIN
- UPHIE, PCE, SEMHIE, Beacon: committed to Common Gateway, Health Provider Directory, Cross QO Query: UPHIE readying for VA use case

## MiHIN – Monthly Message Count



## MiHIN Monday Metrics (M3) Report

									Production messages since May 8, 2012										as of: 12-09-13 for week ending 12-07-13													
New Last Week	Prod. Running Total	Sources in Prod. Through MIHIN	Sources in Prod. Through Temp. URL	Sources in DQA	QOs sending prod. messages	QOs in test	vQOs sending prod. messages	vQOs in test	Use Case Agreement	Category	Use Case Status	Use Case Agreement Status																				
												GLHIE	Ingenium	JCMR	MHC	SEMHIE	UPHIE	SEMBC	MDCH	BCBSM	HAP (HFHS)	CareBridge (VQO)	PCE (VQO)	MHIN (VQO)	MSMS (VQO)	Meridan Health (VQO)						
51,819	2,793,362	457	8	225	3	1	1		Immunization Records Submit (VXU)	Public Health Reporting	ongoing	*FE	NS	NS	*FE	NS	*FE	*FE	*FE	NA	NA	NA	NA	*FE								
10	107				2				Reportable Labs Submission (ELR)	Public Health Reporting	ongoing	FE	NS	NS	*FE	NS	FE	PR	*FE	NA	NA	NA	NA									
37,656	6,084,994				1				Transition of Care - Payers/BCBSM (ADT)	Care Coordination and Patient Safety	ongoing				*FE				*FE													
1,256	80,705				1		0		Admit-Discharge-Transfer (ADT) Spectrum/Carebridge	Care Coordination and Patient Safety	ongoing				*FE						*FE											
1,132,582	4,065,131				3		1		All Patient- All Payer ADT Notification Service	Care Coordination and Patient Safety	ongoing				*FE				*FE	*FE	*FE											
						2			Receive Syndromics	Public Health Reporting	In Pilot/Pending MSSS Approval	NS	NS	NS	NS	NS	*FE	NS	*FE													
									Submit Data to Health Provider Directory	Care Coordination and Patient Safety	Approved by MOAC UCWG																					
									Basic Query to Health Provider Directory	Care Coordination and Patient Safety	Approved by MOAC UCWG																					
									CMS Electronic Submission of Medical Documentation	Care Coordination and Patient Safety	ongoing																					
									SSA disability determination	Care Coordination and Patient Safety	ongoing																					
									Cross-QO Query	Care Coordination and Patient Safety	ongoing																					
									eHealth Exchange patient Query	Care Coordination and Patient Safety	ongoing																					
									VA Patient Query	Care Coordination and Patient Safety	ongoing																					
1,223,323	13,024,299	457	8	225	10	3	2	0	Totals																							



MDCH Data Hub

# December 2013

## Production Updates

- **Newborn Screening** – The legislative mandate is for providers to screen every newborn by 4/1/2014. Requirements gathering has begun for a new Critical Congenital Heart Defects message. Message development will be constructed from the national message guide.
- **MCIR Immunizations** via HIE Platform has grown from 10% of submissions in February 2013 to 18% of submissions in December 2013.

## Technology Development/Implementation

- **MICAM (Michigan Identity Credentialing and Access Management)** – 1. Deloitte provided the MICAM Team and the MiPages Team (Citizen Portal project) an impact analysis for the integration of MiPages and MICAM. The impact analysis is being reviewed by DTMB and DCH. 2. Project preparation activities are taking place, such as the collection of information and categorization of all MDCH and State of Michigan Single Sign On applications. For MDCH applications, distinction is being made between the Medicaid or non-Medicaid applications as the Medicaid applications will be the first to be migrated.

## Technology Infrastructure Development

- **Audit/Logging** - The MDCH Data Hub has always retained logs in order to meet HIPAA logging and audit requirements. Hub efforts have begun to leverage State of Michigan enterprise log management system (TSIEM) to store these logs as well as establish purge procedures and processes to ensure, as new traffic is brought into production, that appropriate logs are retained.

## Meaningful Use Registry Work

- **Cancer Case Report for Cancer Registry** – Implementation Guide has been published on MiHealth.org and the project team has begun working with pilot providers to test their message structure. MDCH Project Charter will be executed soon in order to begin requirements gathering and infrastructure work to prepare for pilot production in March 2014.



## Current Participation Year (PY) Goals


	Reporting Status	Prior Number of Incentives Paid	Current Number of Incentives Paid	Current PY Goal Number of Incentive Payments	Current PY Medicaid Incentive Funding Expended
Eligible Provider (EPs)	AIU	1,177	1,177	1,289	\$23,941,692
	MU	547	547	586	\$4,238,682
Eligible Hospital (EHs)	AIU	13	15	20	\$6,500,000
	MU	22	56	43	\$14,115,393

### Cumulative Incentives for EHR Incentive Program 2011 to Present

	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	2,533	\$143,017,718
MU	618	\$46,782,256

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

# 2013 Goals

	Number of MI Priority Providers	Average Priority Providers (Across RECs Nationwide)	% to Michigan Goal	Average % to Goal (across RECs Nationwide)
<b>Milestone 1 Recruitment:</b> Number of Eligible Priority Providers enrolled into the M-CEITA program	3,724 (+)	2,177(+)	100% (+)	100 % (+)
<b>Milestone 2 EHR Go-Live:</b> Number of Priority Providers that have gone live with an EHR within their organization	3,724(+)	1,971	100% (+)	91%
<b>Milestone 3 Meaningful Use Attestation:</b> Number of Priority Providers that have attested for Meaningful Use	2,277	1,280	61%	59%



## 2013 Goals

Plan, implement, evaluate EHR/HIT/HIE-enabled clinical interventions across health care delivery sites with an emphasis on care coordination.

- Activities include: 46 practice sites (36 min required), 117 PCPs, 17,783 diabetic patients (4000 min required), 180,252 total patients affiliated with Beacon practices for CT intervention engaged to date.
- Patient Health Navigator (PHN) penetration: 5,398 (2400 min required) patients referred, 2,329 engaged. 2013 Goal: 4500+ referred and 1900+ engaged.
- Emergency Department Initiative: 27,000+ patients screened. Prevalence of pre-diabetes:

Plan, implement, evaluate HIE deployment with an emphasis on care coordination toward quality improvement, better population health at lower cost.

- HIE OnBoarding: Build critical mass within BeaconLink2Health (BL2H) as defined. Wayne State University Physicians Group (WSUPG) integration to HIE for both CCD and VXU exchange is days away. While there is no historical load to process, WSUPG has only been on the NextGen platform since 12/12. Post go-live, BL2H patient numbers will begin increasing geometrically compared to the past as the organization has over 400 doctors seeing patients daily.
- Piloting EHR/HIE Integration with 23 practice sites/71 physicians which includes all FQHCs in Wayne County.
- MiHIN Integration: HPD and ADT Notification pilots are underway, identifying pilots for MiHIN Data Hub integration, and CCD Gateway use cases.
- CDR Data Reporting: Leveraging community-level XDS.b clinical data repository for data quality

Provide quarterly qualitative and quantitative data reporting to ONC for evaluation and measurement, and for PDSA cycles across interventions.

- Work with Beacon central to begin leveraging BL2H for data pulls (Pull data out of HIE for Pilot Practices.) Comparison of proportions between practice reported and HIE reported data (as HIE data are made available)
- Finalize patient survey and navigator analyses.

Brand Beacon through regular communications with key stakeholders.

- Development of SEMBC's final Beacon Community report.
- Publish Press Releases and e-Bulletins as needed.
- Ongoing support for the launch and deployment of BeaconLink2Health.
- Six peer-review papers currently active.

### Scalability, Sustainability & Research:

Develop financial sustainability model including plan for scalability. Pursue funding opportunities as appropriate.

- Implement scalability plan and sustainability strategies.
- Plan for future payment reform opportunities.
- Continue to identify and pursue funding opportunities.